TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Charter Oak Fire Insurance Co

MFDR Tracking Number
M4-17-2578-101

Carrier's Austin Representative
Box Number 05

MFDR Date Received
May 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used by establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $725.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement. The Provider billed primary CPT code 26952 (finger amputation) and secondary codes 15240 (full thickness graft) and 93005 (ECG with tracing only), along with several ancillary codes. Per the Table of Disputed Services, the Provider seeks separate reimbursement for CPT codes 15240 and 93005. The Provider apparently contends they are entitled to separate reimbursement for these CPT codes. The Carrier has reviewed the billing edits for these procedures, and determined that CPT codes 15240 and 93005 are included with CPT code 26952 for reimbursement. Consequently, separate reimbursement is not due for this procedure. The ancillary codes are included in the primary procedure reimbursement and are not eligible for separate reimbursement.

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2017	15240, 93005	$725.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital facility

fee guidelines.

1. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
1. 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
2. 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment on the payment status indicator determines the service is packaged or excluded from payment.
3. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
4. W3 – Additional payment made on appeal/reconsideration
5. 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Is the carrier's denial supported for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are related to outpatient hospital services rendered on January 19, 2017. The requestor is seeking additional reimbursement for $725.51. The carrier denied the disputed services as 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS. The specific Medicare payment policy states in pertinent part,

> ***Payment status indicator*** *- The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.*
>
> Review of the Addendum B.-Final OPPS Payment by HCPCS Code for CY 2017 finds;
>
> - Code 15240 – "Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet. Has a status indicator of "T."
> - Code 93005 – "Electrocardiogram tracing. Has a status indicator of "Q1."
> - Code 26952 – "Amputation of finger/thumb. Has a status indicator of "J1."
>
> While Code 26952 is not in dispute, please see below to determine how the definition of the "J1" status indicator "packages" all covered Part B services on the claim.
>
> The definition of each of the above referenced status indicator found at the 2017 Final Addendum D1 is;
>
> - "J1" – Hospital Part B services paid through a comprehensive APC. Paid under OPPS; **all covered Part B services on the claim are packaged with the primary "J1" service for the claim** except services with OPPS SI = F,G,H,L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B Inpatient services.

- "Q1" – STV – Packaged Codes, (1) Packaged payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V."
- "T" – Paid under OPPS; separate APC payment.

Based on the above the carrier's denial of Code 93005 and Code 15240 as 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" is supported as neither of these codes have status indicator's that are exceptions to comprehensive packaging. The carrier's denial is supported.

2. The Division finds per the requirements 28 Texas Administrative Code 134.403 (d), the applicable Medicare payment policy does not allow additional reimbursement for the services in dispute. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 25, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.